Economics, Ethics, and Mental Illness

EXTENSION OF REMARKS
OF
HON. JOHN E. FOGARTY
OF RHODE ISLAND
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Mr. FOGARTY. Mr. Speaker, under leave to extend my remarks I include an address which I delivered at the 11th Mental Hospital Institute, Buffalo, N.Y., on October 20, 1959:

ECONOMICS, ETHICS, AND MENTAL ILLNESS

(Address of the Honorable JOHN E. FOGARTY, Member of Congress, second district, Rhode Island, at the 11th Mental Hospital Institute, at the Hotel Statler in Buffalo, N.Y., on October 20, 1959)

Distinguished guests, ladies and gentlemen, I am greatly honored by your invitation to present the academic lecture at this 11th Annual Mental Hospital Institute. I have a sense of some temerity, however, in addressing a group such as this on the subject of ethics and mental illness. All of you have, in the most practically real and effective way, dedicated yourselves to improving the condition of the mentally ill. The staffs of the outstanding hospitals that have received the Mental Hospital Service Achievement Awards here tonight are in the front echelons of an army of many thousands who work against tremendous odds. These people, despite the magnitude and seeming hopelessness of the task, have made substantial gains in the campaign to improve care and treatment for the mentally ill, to help them recover more rapidly and more fully. As a layman, I can add to your great effort only my indirect help, my understanding, and my support for your work.

I have been closely concerned for a long time, as many of you may know, with the problems of mental and emotional disorders. The prevalence of these illnesses, and the regularity with which they afflict a large proportion of our people in every class and condition of society put them in a critical category all by themselves. If mental illness were acutely contagious instead of causing chronic invalidism and disability, our country and all the countries of the civilized world would long ago have declared a state of emergency against this epidemic.

As a nation, we are painfully aware of the economic costs of mental illness; we have deep sympathy for the misery of those who suffer from mental illness and the hardships endured by their families; we want to do as much as we can to alleviate this suffer-

ing—but we are not sure how much we can afford to do; what limits we should set to our efforts in the light to what we know at present; in what directions we should exert our efforts most vigorously.

The dilemma was posed most succinctly in the recent report on the economics of mental illness. This report is the second in a series being issued by the Joint Commission on Mental Illness and Health as part of a national mental health survey initiated by Congress. The purpose of the survey is to bring together a comprehensive body of findings and recommendations that will serve as the basis for planning a stepped up, comprehensive national mental health program.

Dr. Rashi Fein, the economist who worked out methods for estimating the direct and indirect costs of mental illness in the United States, estimates them conservatively at a minimum of $3 billion each year. This figure obviously does not represent the full cost of mental illness. It includes direct costs of caring for the mentally ill expended by public and private agencies, by the patients and their families, by public institutions and private foundations. It includes estimates of such indirect costs as loss of production and loss of earnings. It does not include the costs of private care outside the hospital, of public assistance to the mentally ill or the handling of the mentally ill by police, court, penal, social welfare and other public institutions. Nor does it include the costs of related problems such as drug addiction, alcoholism, juvenile delinquency, and mental retardation.

The $3 billion figure includes $100 million as an estimated minimum direct cost of care provided by psychiatrists in full-time practice. It does not include the cost of payments to psychiatrists in part-time practice, to general practitioners, or to internists for the care of the mentally ill. I am sure that you who work in the field are well aware of the difficulty of gathering accurate statistics on this subject. It has been estimated that perhaps 50 percent of the patients consulting general practitioners are suffering from complaints of an emotional origin. If this cost were included, we would have to add another $1 billion to our $3 billion annual total.

We all are, of course, painfully aware that even though we pay out $3 billion annually, we are not providing our mentally ill with anything like the best care presently possible. The average expenditure per patient in a public mental hospital is just a little better than $4 a day. This compares with a daily cost of approximately $25 in a general hospital. The staff of the Joint Commission raise some very provocative questions in their preface to Dr. Fein's report. They ask: "How much would it cost to provide the highest possible standard of care for the mentally ill? Can we afford these costs? More exactly, which can we better afford—the cost in human misery caused by mental illness or the cost in dollars to provide the best care we know how to give?"

As a people, we Americans are committed morally and ethically to the proposition that each man and woman is entitled to the opportunity to realize his best capabilities. This includes the opportunity to receive proper medical care, regardless of income, social class, or the nature of the illness. We subscribe to the statement in the constitution of the World Health Organization that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition." However, we are a practical people. We also want to know whether large increases in the money spent to treat mental illness would be justified from an economic as well as a humanitarian viewpoint. Will increased expenditures tend to reduce the extent of the problem in the future? Where will the money come from? Should available increased funds be spent to step up research that hopefully will reduce the problem drastically at some future date—and, in the meantime, limp along with inadequate care for those who now are mentally ill or who become mentally ill in the near future?

From an ethical point of view, I do not believe that we have any choice. We cannot abandon one iota of the available potential for uncovering useful new knowledge through research. Equally, we cannot abandon the mentally ill. We are morally obliged to strive, to the limit of our abilities and resources, to improve the lot of the mentally ill, to make treatment more effective, to increase our efforts at cure and rehabilitation. Certainly people suffering from this illness are entitled to the same consideration as those with physical illness. As you know any person with acute appendicitis, can obtain a good surgeon to remove it regardless of his ability to pay. We do not provide similar services for the mentally ill.

But because our resources are far from unlimited, we must make choices. What kinds of expanded services for the mentally ill are likely to be the most profitable? Where will our efforts be apt to bring the greatest payoff in terms of patient recovery?

Until fairly recently these were questions which could be answered almost solely on empirical evidence. And as a glance back over history will remind you, the answers that were accepted and applied in treatment were colored more often by the intellectual attitudes of the times than by detached analysis. Thus, little of constructive value was done to help the mentally ill in Western Europe until the age of enlightment at the end of the 18th century. Paradoxically, the period of the Renaissance, during which new emphasis was placed on the dignity and worth of the individual, was characterized by cruel and repressive treatment for the mentally ill.

As you know, it was not until the 1800's that a systematic approach to mental illness was predicated on the belief that the mentally ill are entitled to the humane treatment that is the inalienable right of all human beings. This era of moral treatment, based on principles advocated by Pinel and Tuke, stressed the importance of attempting to influence the mentally ill by appealing to them with kindness and understanding rather than by regimenting them. Although it was believed that mental illness was caused by some unknown pathological process in the brain, the advocates of this type of treatment felt that their approach would do much to help their patients.

In that era, there were so few mental hospitals in the United States that only a small fraction of the people who needed hospital care would be admitted, but the hospitals that did exist were operated along excellent principles. They were small. The superintendents were highly intelligent and well motivated. The atmosphere was friendly, comfortable, hopeful, and the superintendent was able to talk to each patient daily. Despite the paucity of treatment methods, the number of discharges and recoveries in these hospitals was substantial.

Further advances in care and treatment were made in the big mental hospitals that were established during the latter half of the 19th century. New discoveries made during the first half of the present century enabled us to conquer the psychoses due to pellagra and general paresis. The use of shock therapy changed the entire picture with respect to involutional melancholia. The various psychotherapies were developed, and much was learned about the anatomy, physiology, and pathology of the nervous system.

In our own day, we have witnessed a period of remarkable progress which began shortly after World War II. Stimulated by the realization that mental and emotional disorders were a dangerous hazard to our safety as a nation, Congress, at that time, initiated our present ongoing program of support for research, training, and service in the field of mental health. In the short span of years since then, this activity has grown manyfold. Equally important, new work in the field of mental illness has been begun and stimulated by State and local government agencies, institutions, private foundations, citizens' organizations, universities and medical schools, training centers, and groups of all types throughout the country.

I have watched this campaign grow and spread, as you all have, and I must say the results have been impressive. New research findings have emerged—the tranquilizers and other psychoactive drugs have come into general use—we have developed new ways of training personnel and using people now available to treat patients—we have set up new kinds of treatment facilities and changed our uses of present facilities. The growth in treatment resources and know-how has been little short of phenomenal. Though we are still far from our goal, we have, I believe, what no previous period had. We have a handle with which to grasp the problem of mental illness. We have some tools that can help us decide, on a scientific basis, where our expanded efforts are most likely to bring results in terms of patient recovery.

Among the more useful tools, it seems to me are the epidemiological studies of mental illness. These studies have provided new knowledge about who becomes ill, how long they remain ill, what happens to the mental patient both in and out of the hospital, and the effects of new therapies and new kinds of domiciliary and outpatient care. This kind of information, obviously, is of first importance in long-range planning and in making critical decisions which will affect the patterns of caring for the mentally ill for decades to come. A great deal of this information has come from the many statistical studies of mental hospital populations sponsored and conducted by the States in the Model Reporting Area for Mental Hospital Statistics, with the guidance, cooperation, and assistance of the National Institute of Mental Health. Experts in this field have charted new ways of analyzing the problems of mental illness.

To me, one of the most significant changes that has taken place in recent years is that communities are assuming more responsibility for the care of the mentally ill. Services and facilities that make it possible to keep people out of mental hospitals and still give them adequate care are being established throughout the Nation.

Of particular importance has been the increase of psychiatric facilities in general hospitals. The numbers of these hospitals accepting psychiatric patients rose from 43 in 1939 to almost 1,000 in 1958.

The increase in the number of outpatient clinics and the extent of their services has been equally phenomenal.

New types of outpatient facilities and day-care and night-care centers have been opened.

Emergency psychiatric services are being developed which hopefully will obviate the need for hospitalization in some instances.

Nursing homes and chronic-disease hospitals are being used more and more for care of such groups as the aged mentally ill.

There has also been an increase in after-care facilities in the community so that patients who have been released are less likely to relapse.

Within the mental hospitals, there have also been significant changes. In fact, from what I have read I would say that there has

been a virtual revolution in the way in which the hospital views and handles the mental patient, a revolution that has been reflected in the more hopeful attitude toward mental illness prevalent throughout our society today. The use of total push programs, begun about 10 years ago, have demonstrated that many backward patients—the ones for whom hope had long since been abandoned—could improve to the point where they can be returned to the community.

The open hospital has been another major step forward in the attempt to prevent long-term hospitalization and its associated ill effects. The healthy activity and sense of purpose that characterize the modern mental hospital are a far cry from the atmosphere that surrounded the mental hospital even as recently as 25 years ago. The idea of the open hospital has come to our shores in recent years from England where it has worked out very successfully in a number of hospitals. As yet it is not so generally accepted here as abroad.

A number of commentators have pointed out an apparent difference in the amount of violence among British and American patients and have suggested that something in the British personality or the more uniform culture in Great Britain may make the open hospital more feasible there than here. But the precedent for patient freedom in this country existed long ago. In 1842, Charles Dickens described, in his "American Notes," scenes in the Boston Lunatic Asylum that would do justice to the more enlightened of our present-day institutions. "Every patient in this asylum," Dickens wrote, "sits down to dinner every day with a knife and fork; * * * At every meal, moral influence alone restrains the more violent among them—but the effect of that influence—is found, even as a means of restraint, to say nothing of it as a means of cure, a hundred times more efficacious than all the strait-waiscots, fetters, and handcuffs. * * *"

One might logically conclude, therefore, that the success of the "open door" is dependent upon a real change in attitude toward the mentally ill. Opening locked doors and giving patients the social freedom that is rightfully theirs is not enough. There must be real conviction on the part of the entire hospital staff that the patient can improve. Patients must be given treatment; all the available therapies—chemotherapy, psychotherapy, physical therapies and so on—must be marshalled and organized on an individual basis so that each patient is given the benefit of all that is now known about treating mental illness.

More and more the hospital must take its place as part of a network of mental health services in the community. The treatment and rehabilitation programs of the hospital need to become more closely integrated with community health and social services, so that the patient can receive continuous psychiatric and social assistance that will change as his needs change—and so that he will be able to maintain his links to the community and to his family throughout the course of his illness.

Dr. Robert Felix, Director of the National Institute of Mental Health and president-elect of your American Psychiatric Association, pointed out this need at your meeting 2 years ago when he said: "I would envision the time when we would consider the hospital period not as a separate entity, but as an entity in the total therapeutic program of the individual." The hospital also must share its responsibilities in the total community forces available for fostering preventive programs and positive mental health activities. Dr. Felix has also said: "* * * members of our hospital staffs are going to be much more effective as a total therapeutic instrument in hospital programs if there are devices set up whereby they must spend some of their time in consultation with other agencies in the community."

This means that hospital staff would become involved in a whole array of community activities—such as industrial mental health, school mental health, the mental health aspects of law enforcement programs, and various community mental health activities in cooperation with civic leaders. Although these activities would, of course, burden the already overcrowded schedule of hospital staff, the benefits would far outweigh the difficulties—and the advantages would probably spur renewed and successful efforts at expanding hospital staff. Closer contact with the community would give the hospital physician, nurse, social worker, and psychologist a clearer understanding of the problems confronting the patient when he leaves the hospital. Such contacts would also stimulate professional personnel and other people working and living in the community to provide services within the hospital and help the hospital staff.

Ideally, if we are to make the mental hospital an effective therapeutic instrument, it must be set within a larger community which itself is a healing community—in which the general climate and the available services tend to minimize the unhealthy stresses which contribute to mental illness, and tend to promote mental health in a positive way. Recent research leaves no doubt that an individual's social environment has a tremendous influence on his mental health. In the hospital, a therapeutic environment means a climate in which the entire staff brings help to the patients and the patients help one another—in which there is increased emphasis on patient self-government and the patient is given more responsibility for managing his own affairs—in which treatment and help and rehabilitation are dominant. In the community a situation conducive to mental health means ready and adequate help for families in trouble, before one of their members breaks down—it means helping families recognize the early signs of mental illness and seek the proper kind of help as soon as possible—it means halfway houses, sheltered workshops and social-therapeutic clubs for discharged patients—it means the establishment of mental health centers to serve as screening and referral agencies—it means psychiatric emergency services and foster-home care and other measures to avoid long-term mental hospitalization.

The problem of avoiding long-term mental hospitalization is perhaps most acute with the aging—the group who are the particular focus of this Mental Hospital Institute. The problem represented by the disproportionately large number of persons 65 years and over being admitted to public mental hospitals will become an even more critical one in the years ahead. It is estimated that by 1980 the number of people 65 years and over in the general population will double. If the current trend remains fixed, the increased numbers of older people in our mental hospitals will be tremendous. This will pose additional problems, because older patients require a great deal of physical and medical care and special staff attention.

This emerging problem suggests increased emphasis on research in many directions. For example, we need to know more about the aging process itself, about the cause of mental illness in the aged, and about the cultural and economic factors that determine choice of the hospital for needed care. Not all patients with mental diseases of the senium are cared for in mental hospitals. There are a variety of other facilities available—homes for the aged, nursing homes, chronic disease hospitals. We need more facts before we can decide which facility can furnish the most appropriate care.

Perhaps we should give more thought to foster home care of the aged patient whose condition does not necessitate hospitalization but who does not have a family able or willing to give him the help he needs. In thinking of such foster care, we should not ignore the contributions that might be made by the increasing numbers of healthy and active older people in our population—people for whom the responsibility of providing a foster home for aged patients would mean the difference between aimlessness and a sense of purpose and being needed that are essential to everyone's mental health. Payments for providing such foster care might mean the difference between self-respecting independence for thousands of healthy elderly people and the economic dependency on others that in itself can breed psychological problems for the aged. Perhaps this approach could help the older people to help themselves.

But the question of institutional or community or home care of the aged mentally ill, as of other types of mental patients, is only one aspect of the problem. The choice of treatment and treatment facility will change with constantly changing medical knowledge about prevention, treatment, and rehabilitation. It will change as attitudes of the community toward mental illness keep changing. It will change as we learn more about the complex interactions of biological, psychological, economic, and social forces that influence mental health and mental illness. The mental hospital is in a strategic position to contribute to the accumulation of that knowledge as well as to test it out with patients. It can be a living laboratory for the study of mental illness. The establishment of research activity within the hospital itself would help to strengthen its ties with university and other research centers, and would make the hospital more attractive as a place to work and learn. In thus branching out into other activities, the mental hospital may help to solve the chronic problems of insufficient staff that has tended to keep it ingrown and isolated in the past.

I am aware that most of these thoughts have occurred to all of you, perhaps many times. I am also aware of the numerous practical problems and obstacles that daily frustrate your attempts to move ahead. But, as you carry on your deliberations at this Institute, and as you work in your respective hospitals throughout the coming year, you should know that there is broad and generous public support for your efforts. I believe I express the feelings of the vast majority of our people when I say that our country is committed to a full program of activity in the field of mental illness, up to the limit of our economic, and scientific abilities.